PRINTED: 04/06/2009 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER SILVER RIDGE HEALTHCARE CENTER SILVER RIDGE HEALTHCARE CENTER SILVER RIDGE HEALTHCARE CENTER SEMANARY STATEMENT OF DEPICIPACIES F 000 INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification and complaint survey conducted at your facility on 1/13/2009 through 1/16/2009. The census at the time of the survey was 131. The sample size was 24 including 3 closed records. There was one complaint investigated during the survey: CPT #NV20356 was Unsubstantiated The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local leave. The following regulatory deficiencies were identified: F 279 SS=D CARE PLANS A facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and ADDIANTON DEPERTMENT OF DEPROVENCES. THE PROVIDERS DEPARTMENT OF DEPARTMENT SIGNATURE THE CARD THE THIS TORKET THE STATE OF DEPARTMENT SIGNATURE THE CARD THE THIS TORKET THE STATE OF THE ADDIANT THE SIGNATURE THE CARD THE THIS TORKET THE STATE THE STATE THE SIGNATURE THE CARD THE THIS TORKET THE STATE THE STATE THE STATE THE STATE THE STATE THE STA	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
STREET ADDRESS, CITY, STATE, ZIP CODE SILVER RIDGE HEALTHCARE CENTER SAMMARY STATEMENT OF DEFICIENCIES CASH DECARD CONTROL (CASH DECIDED BY PULL RECOULD GIVE THAN OF CORRECTION CASH DECIDED BY PULL RECOULATORY OR USE DIENT FYNO INFORMATION) F 000 INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification and complain survey conducted at your facility on 1/1/3/2009 through 1/1/6/2009. The census at the time of the survey was 131. The sample size was 24 including 3 closed records. There was one complaint investigated during the survey. CPT #NV20356 was Unsubstantiated The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified: F 279 SS=D A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timelable to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and			295072	B. WIN	G		01/1	6/2009
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification and complaint survey conducted at your facility on 1/13/2009 through 1/16/2009. The census at the time of the survey conducted at your facility on 1/13/2009 through 1/16/2009. The census at the time of the survey was 131. The sample size was 24 including 3 closed records. There was one complaint investigated during the survey: CPT #NV20356 was Unsubstantiated The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified: F 279 483.20(4), 483.20(k)(1) COMPREHENSIVE F 279 CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and			NTER	•	1	1151 TORREY PINES DR.	•	
This Statement of Deficiencies was generated as a result of the annual Medicare re-certification and complaint survey conducted at your facility on 1/13/2009 through 1/16/2009. The census at the time of the survey was 131. The sample size was 24 including 3 closed records. There was one complaint investigated during the survey. CPT #NV20356 was Unsubstantiated The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified: F 279 SS=D A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION
a result of the annual Medicare re-certification and complaint survey conducted at your facility on 1/13/2009 through 1/16/2009. The census at the time of the survey was 131. The sample size was 24 including 3 closed records. There was one complaint investigated during the survey: CPT #NV20356 was Unsubstantiated The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified: F 279 SS=D A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 000	INITIAL COMMENTS	3	F	000			
highest practicable physical, mental, and	_	a result of the annual and complaint survey 1/13/2009 through 1/1 time of the survey wa 24 including 3 closed. There was one compared with time of the survey: CPT #NV20356 was The findings and compared with the Health Division prohibiting any criminactions or other clain available to any partistate, or local laws. The following regulation identified: 483.20(d), 483.20(k) CARE PLANS A facility must use that to develop, review and comprehensive plan. The facility must develop plan for each resider objectives and timetal medical, nursing, and needs that are identificats assessment.	I Medicare re-certification y conducted at your facility on 1/16/2009. The census at the as 131. The sample size was direcords. I records. I laint investigated during the Unsubstantiated Inclusions of any investigation in shall not be construed as nal or civil investigations, insight for relief that may be younder applicable federal, I comprehensive I comprehensive care in that includes measurable ables to meet a resident's dimental and psychosocial fied in the comprehensive describe the services that are	F	279			
	LAROPATORY	highest practicable p	hysical, mental, and			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		295072	B. WING		01/	16/2009
	OVIDER OR SUPPLIER	NTER	S	STREET ADDRESS, CITY, STATE, ZIP (1151 TORREY PINES DR. LAS VEGAS, NV 89146	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AN CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 279	be required under §4 due to the resident's §483.10, including the under §483.10(b)(4). This REQUIREMENT by: Based on observation review, the facility fail comprehensive care residents (#1). Findings include: 1. Resident #1 was a 1/6/09 with diagnoses Failure, Osteoarthritis Artery Disease, and o Pulmonary Disease. Resident #1 was adm indwelling Foley cath resident's Nursing Ac dated 1/6/09. From 1 #1 was observed to b yellow urine present i At 11:00 AM on 1/16/ Consultant indicated indwelling Foley cath facility, a Catheter Ne Plan form was compl for the catheter. Reg	ng as required under vices that would otherwise 83.25 but are not provided exercise of rights under e right to refuse treatment is not met as evidenced in, interview and record led to develop a plan for 1 of 24 sampled dmitted to the facility on sincluding Congestive Heart is, Atrial Fibrillation, Coronary Chronic Obstructive nitted to the facility with an eter as documented on the lmission Assessment form 1/13 to 1/16/2009, Resident lave a Foley catheter with in the Foley bag. 2009, the Regional Director if a resident with an eter was admitted to the eted Evaluation and Care eted to determine the need ional Director Consultant	F 27			
	indicated the form als care plan.	so acted as the resident's				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		295072	B. WIN	IG		01/1	6/2009
	OVIDER OR SUPPLIER	NTER	•	1	REET ADDRESS, CITY, STATE, ZIP CODE 151 TORREY PINES DR. .AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 279	Evaluation and Care Resident #1. On 1/16 Director of Nursing of	ence a Catheter Need Plan form was completed for //2009 in the afternoon, the onfirmed Resident #1 did ssessment completed and	F	279			
F 315 SS=D	resident who enters to indwelling catheter is resident's clinical concatheterization was now who is incontinent of treatment and services.	t's comprehensive ity must ensure that a	F	315			
	by: Based on observation review, the facility fail indwelling catheter us catheter care for 4 of #21, #12, #19). Finding include: 1. Resident #1 was a diagnoses including Osteoarthritis, Atrial F	is not met as evidenced n, interview, and record ed to medically justify se and provide appropriate 24 sampled residents (#1, dmitted on 1/6/09 with Congestive Heart Failure, Fibrillation, Coronary Artery c Obstructive Pulmonary					
	indwelling Foley cath	nitted to the facility with an eter as documented on the lmission Assessment form					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		295072	B. WIN	IG _		01/1	6/2009
	ROVIDER OR SUPPLIER	NTER	•	1	REET ADDRESS, CITY, STATE, ZIP CODE 1151 TORREY PINES DR. LAS VEGAS, NV 89146	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		LD BE	(X5) COMPLETION DATE		
F 315	dated 1/6/09. From 1. #1 was observed to h yellow urine present i At 11:00 AM on 1/16/ Consultant indicated indwelling Foley cath- facility, a Catheter Ne Plan form was compl- for the catheter. The indicated the form als care plan. No documented evide Evaluation and Care Resident #1. On 1/16 Director of Nursing on thave a catheter a no indwelling cathete 2. Resident #21 was with diagnoses include Tract Infection, Musc Severe Glaucoma, and Resident #21 was ad as documented on th Assessment form dat 1/16/2009, Resident if Foley catheter with yer Foley bag. There was no docum #21 had an order for	2009, the Regional Director if a resident with an eter was admitted to the eted Evaluation and Care eted to determine the need Regional Director Consultant is acted as the resident's ence of a Catheter Need Plan form was completed for 2009 in the afternoon, the onfirmed Resident #1 did ssessment completed and reare plan initiated. admitted on 12/17/2008, ling Pneumonia, Urinary le Weakness, Hypertension, and Anxiety. mitted with a Foley catheter ence Nursing Admission ed 12/17/2008. From 1/13 to ence 12/17/20	F	315			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		295072	B. WIN	IG_		01/1	6/2009
	ROVIDER OR SUPPLIER	NTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1151 TORREY PINES DR. LAS VEGAS, NV 89146	1 0171	0/2003
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 315	(Medical Doctor) order There was no docum #21 had specific physicatheter care and ma At 11:00 AM on 1/16/ Consultant indicated needed for Foley cath Physician orders were and maintenance for indwelling catheter. 3. Resident #12 was resident initially admit and recently re-admit diagnoses including his Stomach Cancer, Urd Staphylococcus Aure Vancomycin-Resistar Weakness, Impaired Obstructive Pulmona Breath, and Chronic In The History and Phys 2/19/08 and 9/3/08, oc closed records indicated diagnosis which reverequired an indwelling The resident had a the The Nursing Admission 1/7/09, indicated the from Valley Hospital validagnosis was evidentits use.	ented evidence Resident sician orders for Foley intenance. 2009, the Regional Director physician orders were neter insertions. Also, a needed for specific care each resident who had an each resid	F	315			

NAME OF PROVIDER OR SUPPLIER SILVER RIDGE HEALTHCARE CENTER LAS VEGAS, NV 89146 PROPRINT RECOULATORY OR LISC IDENTIFYING INFORMATION) F 315 Continued From page 5 when a resident is admitted with a Foley Catheter, staff are to "proceed with catheter orders and care plan development." The resident's Bowel & Bladder Assessment and Management document dated 17/709, indicated the resident was a possible candidate for re-training or individual training for bowel and/or bladder re-training. The two page assessment document indicated no documented evidence of the resident's under usable and cognitively intact and the preferred mode for the resident was alto and cognitively intact and the preferred mode for the resident was to be a toilet. A Physician Progress Note dated 1/8/09, indicated the resident's similal assessment included a plan to admit the resident to the facility, intravenous ambitions, PFI/OT (physical therapy/occupational therapy) evaluation and treatment to improve the patient's functional ability and independence, and nutritional support. Other documentation of the resident's plan were noted, but not readable. There was no documented evidence in the assessment which revealed any catheter orders. The resident's Interim Plan of Care indicated the word "Foley" under Bladder/Bowel Status (#6 in the plan). There was no plan of care or directions of care for staff documented in the plan of care.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
STREET ADDRESS, CITY, STATE, ZIP CODE 1151 TORREY PINES DR. LAS VEGAS, NV 89146 CAPPENDER CAPPE			295072	B. WIN	IG		01/1	6/2009
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 315 Continued From page 5 when a resident is admitted with a Foley Catheter, staff are to "proceed with catheter orders and care plan development." The resident's Bowel & Bladder Assessment and Management document dated 177/09, indicated the resident was a possible candidate for re-training or individual training for bowel and/or bladder re-training. The two page assessment document indicated no documented evidence of the resident's current status of having an individual catheter. It was noted on the second page that the resident was alert and cognitively intact and the preferred mode for the resident was to be a toilet. A Physician Progress Note dated 1/8/09, indicated the resident's initial assessment included a plan to admit the resident to the facility, intravenous antibiotics, PT/OT (physical therapy/occupational therapy) evaluation and treatment to improve the patient's functional ability and independence, and nutritional support. Other documentation of the resident's plan were noted, but not readable. There was no documented evidence in the assessment which revealed any catheter orders. The resident's Interim Plan of Care indicated the word "Foley" under Bladder/Bowel Status (#6 in the plan). There was no plan of care or directions			NTER	•	11	151 TORREY PINES DR.		
when a resident is admitted with a Foley Catheter, staff are to "proceed with catheter orders and care plan development." The resident's Bowel & Bladder Assessment and Management document dated 1/7/09, indicated the resident was a possible candidate for re-training or individual training for bowel and/or bladder re-training. The two page assessment document indicated no documented evidence of the resident's current status of having an indwelling catheter. It was noted on the second page that the resident was alert and cognitively intact and the preferred mode for the resident was to be a toilet. A Physician Progress Note dated 1/8/09, indicated the resident's initial assessment included a plan to admit the resident with the resident was to be a toilet. A Physician Progress Note dated 1/8/09, indicated the resident's initial assessment included a plan to admit the resident to the facility, intravenous antibiotics, PT/OT (physical therapy)-occupational therapy) evaluation and treatment to improve the patient's functional ability and independence, and nutritional support. Other documentation of the resident's plan were noted, but not readable. There was no documented evidence in the assessment which revealed any catheter orders. The resident's Interim Plan of Care indicated the word "Foley" under Bladder/Bowel Status (#6 in the plan). There was no plan of care or directions	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF	PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP		LD BE	COMPLETION
4. Resident #19 was a 90 year-old female resident initially admitted on 11/12/08 and recently re-admitted on 1/8/09, with diagnoses including Depression, Dementia, Hypertension,	F 315	when a resident is ac staff are to "proceed care plan developme." The resident's Bowel Management docume the resident was a pore-training or individual bladder re-training. It document indicated in the resident's current indwelling catheter. It page that the resident intact and the preferrowas to be a toilet. A Physician Progress indicated the resident included a plan to ad intravenous antibiotic therapy/occupational treatment to improve ability and independent of the documentation noted, but not readalt documented evidence revealed any cathete. The resident's Interim word "Foley" under But the plan). There was of care for staff documently re-admitted of the staff and the plan initially admirecently re-admitted of the staff and the staff and the plan initially admirecently re-admitted of the staff and the plan initially admirecently re-admitted of the plan initial plan initially admirecently re-admitted of the plan initial plan initi	Imitted with a Foley Catheter, with catheter orders and nt." & Bladder Assessment and ent dated 1/7/09, indicated besible candidate for all training for bowel and/or. The two page assessment no documented evidence of status of having an training an training an training and training and the second training and the resident. Solve the dated 1/8/09, the initial assessment mit the resident to the facility, as, PT/OT (physical therapy) evaluation and the patient's functional ence, and nutritional support. The form of the resident which are orders. The Plan of Care indicated the ladder/Bowel Status (#6 in no plan of care or directions mented in the plan of care. The plan of care or directions mented in the plan of care.	F	315			

NAME OF PROVIDER OR SUPPLIER SILVER RIDGE HEALTHCARE CENTER SILVER RIDGE HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICITIONIES SUMMARY STATEMENT OF DEFICITIONIES REACH DEPICIENCY MUST BE PRECEDED BY PULL RECOLATION OF LOC DEPITIFYING INFORMATION) F 315 Continued From page 6 Coronary Artery Disease, Congestive Heart Failure, Muscle Weakness, Galt Impairment, Dysphagia, Symbolic Dysfunction, C. Difficile Collits, Metabolic Myoopathy, Recurrent Falls, Chronic Gastritis, Diverticultis, Osteoarthritis, Renal Insufficiency, Hyperkalemia, Hypernatremia, and Anemia. The current History and Physical Examination dated 19/09, indicated the resident was re-admitted to the facility following a transfer from Southern Hills Hospital due to cheat congestion. There was no mention of the resident having an indwelling catheter and/or diagnosis which required the resident to have a catheter. The Nursing Admission Assessment dated 1/8/09, indicated a Foley Catheter was present upon the resident's re-admission, indicated an order on 1/8/09 for Foley Catheter care every shift. There was diagnosis was evident in the space provided for its use. The facility's Medication Record for 1/2009, following the re-admission, indicated an order on 1/8/09 for Foley Catheter care every shift. There was diagnosis indicated on the record which supported the use of the catheter or the actual care required. The resident's Interim Plan of Care dated 1/8/09, indicated the word "Foley Catheter" under the "Tolleting" section. However, there was no documented evidence of a plan of care or directions of care for staff documented in the plan of care. A Physician Telephone Order dated 1/14/09, indicated an order to D/C (discontinue) Foley	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
SILVER RIDGE HEALTHCARE CENTER SILVER RIDGE HEALTHCARE CENTER (NATION 100 1990 1			295072	B. WIN	IG _		01/1	6/2009
FREETIX TAG REGULATORY OR LSC DENTIFYING INFORMATION) F315 Continued From page 6 Coronary Artery Disease, Congestive Heart Failure, Muscle Weakness, Gait Impairment, Dysphagia, Symbolic Dysfunction, C. Difficile Colitis, Metabolic Myopathy, Recurrent Falls, Chronic Gastritis, Diverticulitis, Osteoarthritis, Renal Insufficiency, Hyperkalemia, Hypernatremia, and Anemia. The current History and Physical Examination dated 19/99, indicated the resident was re-admitted to the facility following a transfer from Southern Hills Hospital due to chest congestion. There was no mention of the resident having an indwelling catheter and/or diagnosis which required the resident to have a catheter. The Nursing Admission Assessment dated 1/8/09, indicated a Foley Catheter was present upon the resident's re-admission and no diagnosis was evident in the space provided for its use. The facility's Medication Record for 1/2009, following the re-admission, indicated an order on 1/8/09 for Foley Catheter care every shift. There was diagnosis indicated on the record which supported the use of the catheter or the actual care required. The resident's Interim Plan of Care dated 1/8/09, indicated the word "Foley Catheter" under the "Toiletting" section. However, there was no documented evidence of a plan of care or directions of care for staff documented in the plan of care. A Physician Telephone Order dated 1/14/09,			NTER	•	1	1151 TORREY PINES DR.		
Coronary Artery Disease, Congestive Heart Failure, Muscle Weakness, Gaif Impairment, Dysphagia, Symbolic Dysfunction, C. Difficile Colitis, Metabolic Myopathy, Recurrent Falls, Chronic Gastritis, Diverticulitis, Osteoarthritis, Renal Insufficiency, Hyperkalemia, Hypernatremia, and Anemia. The current History and Physical Examination dated 1/9/09, indicated the resident was re-admitted to the facility following a transfer from Southern Hills Hospital due to chest congestion. There was no mention of the resident having an indwelling catheter and/or diagnosis which required the resident to have a catheter. The Nursing Admission Assessment dated 1/8/09, indicated a Foley Catheter was present upon the resident's re-admission and no diagnosis was evident in the space provided for its use. The facility's Medication Record for 1/2009, following the re-admission, indicated an order on 1/8/09 for Foley Catheter care every shift. There was diagnosis indicated on the record which supported the use of the catheter or the actual care required. The resident's Interim Plan of Care dated 1/8/09, indicated the word "Foley Catheter" under the "Toileting' section. However, there was no documented evidence of a plan of care or directions of care for staff documented in the plan of care. A Physician Telephone Order dated 1/14/09,	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
Catheter. This order was written following an	F 315	Coronary Artery Dise Failure, Muscle Weak Dysphagia, Symbolic Colitis, Metabolic Myd Chronic Gastritis, Div Renal Insufficiency, Hypernatremia, and A The current History a dated 1/9/09, indicate re-admitted to the fact Southern Hills Hospit There was no mention indwelling catheter ar required the resident The Nursing Admission 1/8/09, indicated a Foupon the resident's rediagnosis was evidentis use. The facility's Medicate following the re-admitative set of care required. The resident's Interimindicated the word "F" "Toileting" section. He documented evidence directions of care for of care. A Physician Telephorindicated an order to	ase, Congestive Heart kness, Gait Impairment, Dysfunction, C. Difficile opathy, Recurrent Falls, erticulitis, Osteoarthritis, dyperkalemia, Anemia. Ind Physical Examination and the resident was illity following a transfer from all due to chest congestion. In of the resident having an ind/or diagnosis which to have a catheter. In Assessment dated oley Catheter was present e-admission and no it in the space provided for Ion Record for 1/2009, ssion, indicated an order on eter care every shift. There ed on the record which the catheter or the actual In Plan of Care dated 1/8/09, oley Catheter" under the ovever, there was no e of a plan of care or staff documented in the plan The Order dated 1/14/09, D/C (discontinue) Foley	F	315			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		295072	B. WIN	IG		01/1	6/2009
	OVIDER OR SUPPLIER	NTER		11	EET ADDRESS, CITY, STATE, ZIP CODE 151 TORREY PINES DR. AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 315		th nursing staff into the nt #19 had an indwelling		315 371			
SS=D	The facility must - (1) Procure food from considered satisfacto authorities; and	sources approved or ry by Federal, State or local stribute and serve food					
	by: Based on observation facility failed to serve conditions.	is not met as evidenced ns and record review, the food under sanitary					
	the following deficient 1. The chlorine base tested three times for	d chemical dishwasher was chlorine with the facilities					
	minimum 50 parts pe chlorine level. The cl the last chlorine test v Note: The dishwashe out to the facility and	d failed to produce the r million (ppm) residual hlorine test log indicated that was done on 1/11/09. er service company came repaired the dishwasher on brought to the attention of the					

The state of the s		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		295072	B. WIN	G		01/16/2009	
	OVIDER OR SUPPLIER	NTER	'	11	EET ADDRESS, CITY, STATE, ZIP CODE 151 TORREY PINES DR. AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 371	refrigerator. 4. The hand wash sin not secured to the wash	sidents in the walk-in e not covered. en light bulb in the walk-in nk by the dishwasher was		371			
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.		F	431			
		y and cautionary					
	facility must store all olocked compartments	tate and Federal laws, the drugs and biologicals in s under proper temperature only authorized personnel to eys.					
	permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when t	ride separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and nd other drugs subject to the facility uses single unit ution systems in which the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		295072	B. WIN	IG_		01/1	6/2009
	OVIDER OR SUPPLIER	NTER			TREET ADDRESS, CITY, STATE, ZIP CODE 1151 TORREY PINES DR. LAS VEGAS, NV 89146	0.77	5/2000
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 431	Continued From page quantity stored is min be readily detected.	e 9 imal and a missing dose can	F	43 ⁻	1		
	by: Based on observation	is not met as evidenced n, the facility failed to ensure were discarded in a timely					
	Findings include:						
	On 1/14/09 at 3:40 PM, the locked medication box in the Medication Room #1 refrigerator contained:						
	per milliliter) with an e b) seven one milliliter milligrams per millilite 4/08; and c) four one milliliter vi	of Lorazepam (2 milligrams expiration date of 11/07; vials of Lorazepam (2 er) with an expiration date of als of Lorazepam (2 er) with an expiration date of					
	were intermingled wit expiration date of 201 On 1/14/09 at 3:45, E the vials had expired	he expiration date of 4/08 h two vials displaying an 11, in a small "ziplock" bag. Imployee #1 acknowledged and should have been ed on the last day of the					